

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2013	
NAME OF PROVIDER OR SUPPLIER GREEN TREE AT POST ROAD				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: February 18, 19, and 20, 2013</p> <p>Facility Number: 011799 Provider Number: 011799 AIM Number: N/A</p> <p>Survey Team: Karina Gates BHS TC Beth Walsh RN Courtney Mujic RN Gloria Bond RN</p> <p>Census Bed Type: Residential: 32 Total: 32</p> <p>Census Payor Type: Other: 32 Total: 32</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/27/13 by Suzanne Williams, RN</p>		R000000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R000029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview, and record review, the facility failed to maintain resident's individual personalities and dignity by not addressing residents by name and administering medication in a common area. This affected 5 residents during random observations. (Resident #4, #12, #8, #6, and #7)</p> <p>Findings include:</p> <p>1. During a medication administration observation, on 2/19/13 at 1:05 p.m., of eye drops for Resident # 4, LPN #2 went over to the Resident, while he was sitting in his wheelchair, in the 1st Floor Lounge, with other residents in the room. LPN #2 then administered eye drops in plain view of the other residents in the common room, while the resident had his head tilted back.</p> <p>On 2/19/13 at 2:40 p.m., during an interview with the Director of Wellness (DoW), she indicated when administering medication, including eye drops, a nurse was supposed to maintain a resident's privacy and</p>	R000029	<p>R 029 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Licensed Staff will use proper procedures for delivery of medication to a Resident. All Staff will address the Residents properly showing respect to the individual personalities and dignity. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected by the deficient practice. The corrective action will be to educate and in-service the Licensed Staff on proper procedure for delivery of medication to a Resident. All Staff will be re-in-serviced on the Residents Rights with emphasis on respect to the individual personalities and dignity. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; There is a huge emphasis on the Residents Rights as a portion of the Orientation Program. There will be an added emphasis on the specific</p>		04/10/2013		

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	<p>dignity and move the resident to a private area out of view of other residents.</p> <p>2. During an observation of medication administration with LPN #2, on 2/19/13 at 1:10 p.m., LPN #2 went over to Resident #8 and gave her a pill to swallow. The Resident looked up at LPN #2 and LPN #2 indicated, to "put it (the pill) in your mouth, baby."</p> <p>During a random observation at 1:15 p.m., on 2/19/13, CNA #4 was assisting Resident #12 into a recliner chair. Resident #12 indicated she would like to sit in the recliner and CNA #4 said, that was "what we about to do, baby."</p> <p>A medication administration observation was made at 1:23 p.m., on 2/18/13, of LPN #2 giving Resident #12 her medication. The resident indicated she didn't feel well and LPN #2 indicated, "this might help, babe."</p> <p>During an interview with the DoW, on 2/18/13 at 2:39 p.m., she indicated staff was expected to address residents by their name and this was to be done to maintain resident's dignity.</p>		<p>orientation and education in-servicing will be accomplished for All Staff to prevent the deficient practice from recurring.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Nursing Director or her Designee will monitor randomly the Staff for compliance, and document the findings three times the first month, two times the second month, and one time the third month. The results of the monitoring will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. By what date the systemic changes will be completed. April 10, 2013</p>				

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	<p>In a policy titled, Residents [sic] Rights, received by the Administrator on 2/20/13 at 10:00 a.m., it indicated, "Residents do not leave their individual personalities or basic human rights behind when they move to an assisted-living facility....Our residents have the right to...1. to be treated with dignity and respect...6. be treated fairly, courteously, and with respect by all staff. "</p> <p>3. During a random observation of a staff member providing medication to residents in the 1st floor lounge on 2/19/2013 at 9:39 am, LPN #2 indicated, "[Resident #6's name], take these baby. Good job sugar." At 9:42 am, LPN #2 indicated, "[Resident #7's name], I have to give it to you baby. Here sweetie, here's your water. You're welcome honey." After the resident handed back her water cup, LPN #2 said, "Good girl, honey."</p> <p>A policy titled, "Protecting and ensuring residents rights" indicated, "4. All staff will receive training on resident rights prior to assignment."</p>						

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure at least 12 fire drills, one quarterly on each shift, were conducted in the year of 2012. This had the potential to affect 32 of 32 residents in the facility.</p> <p>Findings include:</p> <p>Verification of all fire drills conducted since 12/20/11 were requested from the E.D. (Executive Director) on</p>	R000092	<p>R 092 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential of being affected by this deficient practice. The corrective action is to in-service and educate the new Maintenance/Safety Director. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient</p>		04/10/2013		

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	<p>2/19/13 at 10:30 a.m. She provided documentation that indicated fire drills were conducted on the following dates and shifts in the year 2012:</p> <p>7/31/12 - 2nd shift 9/28/12 - 2nd shift 10/30/12 - 1st shift 11/26/12 - 1st shift 12/7/12 - 2nd shift 12/9/12 - 2nd shift</p> <p>During an interview with the E.D. on 2/19/13 at 10:45 a.m., she stated, "We haven't been doing them...."</p> <p>The policy entitled "Training and Disaster Drills" was provided by the E.D. on 2/20/13 at 11:00 a.m. It indicated, "Fire Drills will be held on each shift at least quarterly. No less than 12 drills per licensed building will be conducted annually."</p>			<p>practice does not recur; The Executive Director will track the drills monthly to ensure the deficient practice does not recur.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director will set a date each month to monitor the drills by shift, ensuring the drills have been performed monthly. The results of the monitoring of the drills will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. By what date the systemic changes will be completed.</p> <p>April 10, 2013</p>			

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R000145	<p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observation, interview and record review, the facility failed to ensure cognitively impaired residents did not have access to sharp objects and hazardous chemicals in the kitchen. This had the potential to affect 23 of 32 residents in the facility.</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the E.D. (Executive Director) on 2/19/13 at 1:00 p.m.</p> <p>An observation of the 1st floor kitchen area, openly adjoined to the resident common area, was made. In an unlocked cabinet, underneath the kitchen sink, bathroom cleaner, stainless steel cleaner, and wrinkle releaser was observed.</p> <p>The MSDS (Material Safety Data Sheets) were provided by the E.D. on 2/20/13 at 10:00 a.m. for the above 3 products. They indicated the following:</p> <p>Stainless Steel Cleaner</p>	R000145	<p>R 145 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The door under the sink is locked. The drawer containing silverware is locked. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected. The corrective action will be to in-service All Staff to properly lock all doors and drawers. R 145 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Samara Unit doors and drawers will be checked after each meal to ensure the deficient practice does not recur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Nursing Director or her Designee will monitor randomly the Samara Unit doors and drawers for compliance three</p>		04/10/2013		

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	<p>"HAZARDS IDENTIFICATION. EMERGENCY OVERVIEW: CAUTION! COMBUSTIBLE LIQUID. MAY BE MODERATELY IRRITATING TO EYES AND SKIN. PRINCIPLE ROUTES OF EXPOSURE: EYES, SKIN, INGESTION, INHALATION. POTENTIAL ACUTE HEALTH EFFECT. EYES; MAY BE MODERATELY IRRITATING TO EYES. SKIN: MAY BE MODERATELY IRRITATING TO SKIN. INHALATION: MAY BE IRRITATING TO NOSE, THROAT AND RESPIRATORY TRACT. INGESTION: MAY BE IRRITATING TO MOUTH, THROAT AND STOMACH. MAY CAUSE ABDOMINAL DISCOMFORT, NAUSEA, VOMITING AND DIARRHEA. MAY BE HARMFUL IS (SIC) SWALLOWED. MEDICAL CONDITIONS AGGRAVATED: PERSONS WITH PRE-EXISTING SKIN DISORDERS MAY BE MORE SUSCEPTIBLE (SP)TO IRRITATING EFFECTS."</p> <p>Wrinkle Releaser "Acute Health Effects: From MSDS HAZARDS IDENTIFICATION Health Hazards (Acute and Chronic): EYE: May cause irritation unless rinsed immediately and thoroughly with water SKIN: Prolonged exposure</p>		<p>times a week for the first month, two times a week for the second month, and one time a week for the third month. The results of the monitoring will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. By what date the systemic changes will be completed. April 10, 2013</p>				

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	<p>may cause irritation. INHALATION: Prolonged exposure may cause mild lung irritation. INGESTION: Amounts which may be swallowed as a result of handling are not likely to cause injury. Ingestion of larger amounts may cause injury. Chronic Health Effects: From MSDS HAZARDS IDENTIFICATION Health Hazards (Acute and Chronic): EYE: May cause irritation unless rinsed immediately and thoroughly with water. SKIN: Prolonged exposure may cause irritation. INHALATION: Prolonged exposure may cause mild lung irritation. INGESTION: Amounts which may be swallowed as a result of handling are not likely to cause injury. Ingestion of larger amounts may cause injury."</p> <p>Bathroom Cleaner "HAZARDS IDENTIFICATION. CAUTION. MAY BE MILDLY IRRITATING TO EYES. MAY BE MILDLY IRRITATING TO SKIN. CONTENTS UNDER PRESSURE. Principle routes of exposure: Eye contact. Skin contact. Inhalation. Eye contact: May be mildly irritating to eyes. Skin contact: May be mildly irritating to skin. Prolonged or repeated contact may result in defatting and/or mild, transient irritation."</p>						

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	<p>In the 2nd floor kitchen, openly adjoined to the resident common area, in an unlocked drawer, butter knives and forks were observed. During an interview with the Wellness Director on 2/19/13 at 2:55 p.m., she indicated, "The drawers should be locked."</p> <p>During an interview with the E.D. on 2/20/13 at 11:15 a.m. regarding the unlocked cabinet with chemicals and unlocked drawer with forks and knives, she indicated, "The drawers should have been locked."</p> <p>On 2/20/13 at 11:15 a.m., the E.D. provided a list of 23 ambulatory residents on the 1st and 2nd floors of the facility. She stated, "Everyone has a diagnoses of dementia and considered cognitively impaired."</p>						

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R000185	<p>410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall:</p> <p>(1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level.</p> <p>(2) Provide each resident the following items upon request at the time of admission:</p> <p>(A) A bed:</p> <p>(i) of appropriate size and height for the resident;</p> <p>(ii) with a clean and comfortable mattress; and</p> <p>(iii) with comfortable bedding appropriate to the temperature of the facility.</p> <p>(B) A bedside cabinet or table with a hard surface and washable top.</p> <p>(C) A cushioned comfortable chair.</p> <p>(D) A bedside lamp.</p> <p>(E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device.</p> <p>(3) Provide cubicle curtains or screens if requested by a resident in a shared room.</p> <p>(4) Provide a method by which each resident may summon a staff person at any time.</p> <p>(5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.</p> <p>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.</p> <p>(7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have</p>						

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	<p>clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were provided with a method by which to summon a staff person at any time for 28 of 32 residents in the facility.</p> <p>Findings include:</p> <p>An environmental tour of the facility was conducted with the E.D. (Executive Director) on 2/19/13 at 1:00 p.m.</p> <p>During observation of Residents' #10, 16, 1, 2, 24, 28 and 29 rooms, a push button pendant in which to summon a staff person was observed, affixed, in each restroom. A method in which to summon a staff person could not be found in any other location in the above residents' rooms. During an interview with the E.D. at this time, she indicated pendants are located in each resident's restroom and some have a pendant attached to their person.</p> <p>On 2/20/13 at 10:00 a.m., the E.D. provided a list of the 32 residents in</p>	R000185	<p>R 185 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Pendants are in each Resident's rest-room. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents residing on the Memory Care Unit have cognition deficits and are unable to utilize a portable and / or any pendant effectively, however a pendant has been placed in each Residents rest-room. Because we recognize the Resident cognitive abilities the Staff consistantly monitors the Residents living on the Memory Care Unit What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Staff will be re-in-serviced / educated to consistently monitor all Residents living on the Memory Care Unit. R 185 How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality</p>		04/10/2013		

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	<p>the facility. It indicated 28 of them had a pendant only in their bathroom and 4 of them had a pendant in their bathroom as well as on their person.</p> <p>During an interview with the Wellness Director on 2/19/13 at 2:45 p.m., she indicated "most residents yell" if they need something and that the staff constantly do rounds to ensure residents' safety and well-being. She indicated there are 2 CNA's (Certified Nursing Assistants), 1 housekeeper, and 1 nurse on duty during the night shift to care for the 32 residents.</p>		<p>assurance program will be put into place; and The Nursing Director or Designee will monitor randomly the Staff to ensure they are consistently monitoring the Memory Care Residents. The Nursing Director or her Designee will monitor 3 times a week during the first month, two times during the second month, and one time during the third month. Monitoring will be on going. By what date the systemic changes will be completed. April 10, 2013</p>				

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R000275	<p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p> <p>Based on record review and interview, the facility failed to ensure a diet order was received for 1 of 7 residents reviewed for diet orders in the sample of 7. (Resident #28)</p> <p>Findings included:</p> <p>1. The clinical record for Resident #28 was reviewed on 2/19/13 at 11:30 a.m. Resident #28 was admitted to the facility on 6/5/12.</p> <p>The diagnoses for Resident #28 included, but were not limited to: dementia.</p> <p>Upon review of the February, 2013 physician's orders, no diet order could be found.</p> <p>During an interview with the Wellness Director on 2/19/13 at 2:10 p.m., she indicated she could not find Resident #28's diet order and that diet orders were to be received "upon admission, absolutely."</p>	R000275	<p>R 275 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; A diet order has been obtained for Resident #28. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected by the deficient practice. An audit will be performed to identify if any other Resident does not have a diet order. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Diet Order will be placed on the admission chart audit sheet to ensure the deficient practice does not recur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Nursing Director or her Designee, or Dietary Director or her Designee will monitor randomly three times a week for the first month, two times a week for the second month and one time a month for</p>		04/10/2013		

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	A "Dietary services policy" provided by the Wellness Director, on 2/20/2013 at 11:00 am, indicated, "15. Orders for modified diets are transmitted from the Nursing Department to the Dietary Services Department, where they are kept on file. Nursing personnel shall inform the Dietary Services Department of any pertinent communications such as food likes, dislikes, for residents who may be at nutritional risk. 16. The diet order form shall include at least, resident name, room number, type of diet, physicians name, reason for sending the form, and be dated and initialed by the nurse completing the transmission. Diet orders shall be kept on file in the Dietary Services Department."				the third month. The results will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. R 275 By what date the systemic changes will be completed. April 10, 2013		

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure clinical records were complete, by not following a physician's order for a lab and missing physician orders and labwork. This affected 1 of 5 residents who were reviewed for chart completeness, in a sample of 7. (Resident #4).</p> <p>Findings include:</p> <p>The clinical record for Resident #4 was reviewed on 2/18/13 at 12:45 p.m. The diagnoses for Resident #4 included, but were not limited to: AV block (heart block), pacemaker, and hypertension.</p> <p>a. A Physician's Order, dated 11/20/12, indicated an UA with C/S (urinalysis with culture/sensitivity) was ordered, along with an INR, BMP, and CBC (lab tests).</p>	R000349	<p>R 349 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Physician was notified of the missed UA lab for Resident #4. The Physician did not order an INR for the time indicated by the surveyor for Resident #4. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken; All Residents have the potential to be affected by the deficient practice. The corrective action will be to perform an audit of labs ordered by each Resident's Physician for the past 30 days. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A lab book will be kept in each Nurses Station, with a copy of the lab order. When the lab results are documented the copy</p>		04/10/2013		

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	<p>A copy of the UA results were not located in the chart and was requested, on 2/18/13 at 1:48 p.m., from the Director of Wellness (DoW).</p> <p>During an interview with the DoW, on 2/18/13 at 1:48 p.m., she indicated when staff would perform a UA, it was written in the Nurse's Notes, but she did not locate that information when she looked in the clinical record. She also indicated, she will call the lab to obtain a copy of the lab that was ordered.</p> <p>On 2/19/13 at 1:50 p.m., the DoW indicated the UA was not performed. The DoW also indicated lab tracking was done by placing the order on the MAR (Medication Administration Record) and would be initialed/dated/blocked out when the lab was returned with results. She also indicated Physician's Orders should be followed as ordered and was not sure why the UA was missed and not performed.</p> <p>During a review of the November 2012 MAR, the UA order was located on the MAR, but there was no date or any other indication the lab was completed.</p> <p>b. Further review Resident #4's</p>		<p>is removed from the front of the book to the back of the book to ensure that the deficient practice does not recur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Nursing Director or her Designee will randomly perform audits for labs ordered. The lab audits will be performed three times a week for the first month, two times a week for the second month, and one time a week for the third month to ensure the deficient practice does not recur. The results of the audits will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. By what date the systemic changes will be completed. April 10, 2013</p>				

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	<p>clinical record indicated the following:</p> <p>-The November 2012 MAR (Medication Administration Record) indicated Resident #4 was taking Coumadin (blood thinner) 2.5 mg (milligrams) on Tuesday and Saturday. It also indicated Coumadin 5 mg was given on Sunday, Monday, Wednesday, Thursday, and Friday. Both of these orders had a hand-written note indicating these orders were changed on 10/25/12.</p> <p>-The November 2012 MAR indicated, by the marks/initials in the dated slots, Coumadin 5 mg was given once daily Monday through Saturday [sic]. The MAR indicated the dose of Coumadin was given daily 11/1/12-11/15/12, held on 11/16/12, given on 11/17/12, not given on 11/18/12, given on 11/19/12-11/23/12, and the Coumadin order was changed on 11/24/12. There was no date indicated in this section of the MAR for this Coumadin dose, but another section of the November MAR indicated to continue the present dose of Coumadin on 11/1/12 and 11/8/12.</p> <p>-The November MAR indicated Coumadin 2.5 mg was given on 11/18/12.</p> <p>-The November MAR indicated to hold Coumadin for 2 days and then</p>						

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	<p>initiate Coumadin 5 mg every other day and Coumadin 2.5 mg was to be given on the alternate every other day. The MAR indicated this order started on 11/24/12. The MAR indicated this dosing schedule was given by the marks/initials in the dated slots.</p> <p>-The November 2012 MAR indicated an INR lab draw (lab test to determine blood clotting) was to be drawn on 11/1/12, 11/8/12, 11/15/12, and 11/29/12. The MAR indicated these labs were drawn, since the dates indicated, were blocked out with marks/initials in the slot.</p> <p>-A Physician's Order dated, 11/29/12-no time indicated, indicated no change in Coumadin dose and to draw an INR on 12/6/12;</p> <p>-A Physician's Order, dated 12/6/12 at 7:30 p.m., indicated no change in Coumadin dose and to draw an INR on 12/13/12;</p> <p>-A Physician's Order, dated 12/13/12 at 8:30 p.m., indicated to draw an INR on 12/20/12 and to change the Coumadin dose to 2.5 mg (milligrams) on Tuesday, Thursday, Saturday and to change the Coumadin dose to 5 mg on Monday, Wednesday, Friday, and Sunday.</p> <p>-A Physician's Order dated, 12/20/12 at 8:00 p.m., indicated no change in Coumadin dose and to draw an INR</p>						

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	<p>on 12/27/12.</p> <p>No new Physician's Orders, for INR lab draws, were located, in the clinical record for the month of January 2013, after the 12/27/12 INR lab draw.</p> <p>There were no copies of INR lab reports located in the clinical record, for January. Physician's Orders for January INR lab draws and January lab reports were requested, to the Director of Wellness, at 1:30 p.m., on 2/18/13.</p> <p>A lab report, dated 2/7/13, indicated Resident #4's INR was 1.7. There was a (L) next to the lab value, which indicated the lab value was out of range and was low. The normal range, as indicated by the lab report, was 2.0-3.0.</p> <p>During an interview with the Director of Wellness (DoW), on 2/18/13 at 1:30 p.m., she indicated the staff was supposed to follow Physician's Orders and the MD (medical doctor) typically orders weekly or bi-weekly lab draws, for residents on Coumadin. She also indicated the MD checks the labs/orders on their weekly rounds. The DoW also indicated she was unsure why there were no Physician's Orders for INR lab draws in January and it seemed unusual, but she would check with the MD.</p>						

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	<p>On 2/19/13 at 10:26 a.m., the DoW indicated there were no INR lab draws ordered for January. She also indicated, the MD indicated he missed ordering the INRs for January.</p> <p>A Physician's Order, dated 2/18/13 at 8:00 p.m., indicated an INR lab draw was to be drawn on 2/21/13 and then every 4 weeks after.</p>						

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R000410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure a TB (tuberculin) skin test was completed within 3 months of admission or upon admission for 1 of 7 residents reviewed for tuberculin skin testing in the sample of 7. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was reviewed on 2/19/13 at 11:30 a.m. Resident #28 was admitted to the facility on 6/5/12.</p>	R000410	<p>R 410 What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #28 did receive a TB skin test and the series was restated on 8-28-2012. An audit by the Nursing Director discovered the test needed to be restarted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected by the deficient practice. The corrective</p>		04/10/2013		

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	<p>The diagnoses for Resident #28 included, but were not limited to: dementia.</p> <p>The "Summary of TB Testing, Immunization and Vaccination Record" indicated Resident #28 was given an initial TB test on 7/10/12 that was read on 7/12/12. The second step was given on 8/28/12 and was read on 8/30/12. A notation on the side of this record indicated, "series re-started 8/28/12." No information could be found in the clinical record to indicate Resident #28 received a TB test prior to admission to the facility.</p> <p>During an interview with the Wellness Director on 2/19/13 at 2:10 p.m., she indicated the 1st step TB test should be received "upon admission, absolutely." She indicated she did not know how Resident #28's initial TB test was missed on admission or how the 2nd step was missed after the initial 7/10/12 TB test.</p> <p>The Medical Record Policy was provided by the E.D. (Executive Director) on 2/20/13 at 10:00 a.m. It indicated, "The Mantoux test shall be completed within three (3) months prior to admission or administered upon admission and read within</p>		<p>action will be to perform an audit of the Residents TB skin testing or chest x-ray per Physician order . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The TB / X-ray date given will be placed on the admission chart audit sheet to ensure the deficient practice does not recur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Nursing Direct or her Designee will audit the admission chart of each new Resident for the next three months. The results of the audit will be discussed at the monthly quality assurance compliance meeting. Monitoring will be on going. By what date the systemic changes will be completed. April 10, 2013</p>				

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	seventy-two (72) hours. Residents receiving their first Mantoux test at the time of admission, shall have a second Mantoux administered at least one week and no more than three weeks after the first test unless there is documentation of a previous negative reading of a Mantoux test within the last twelve months, or there is documentation of a previous second-step testing from another facility."						